

Medicare in Crisis  
Testimony  
House Budget Committee  
Thomas R. Saving  
Director, Private Enterprise Research Center, Texas A&M University,  
Public Trustee, Social Security and Medicare Trust Funds,  
and Senior Fellow, National Center for Policy Analysis

As Congress considers legislation to add a prescription drug benefit to Medicare, it is important to understand the financial condition of current Medicare. In less than a decade the combined Social Security and Medicare programs will go from providing net revenue to the Treasury to requiring a revenue transfer. Even though this year's Trustees' Report shows slightly better short-term news coupled with slightly worse long-term news, from the perspective of the total federal budget, these programs will impose significant costs even in the near term. The fact that the Trustees 2002 estimates of Trust Fund exhaustion dates are three years later for Social Security and one year later for Medicare HI has obscured the reality that the demands of these programs on the rest of the budget will begin in just a few years. A total budget perspective is important because though Social Security and Medicare HI have Trust Funds, when revenues into the combined system fall below expenditures, real resources must come from somewhere else in the federal budget.

The total budget perspective good news is that, in spite the fact that last year almost 78% of Medicare Part B expenditures were paid by general revenue transfers, surpluses in Social Security and Medicare Part A were sufficient so that these three programs, Social Security, Medicare Part A and Medicare Part B, made a net contribution to the U.S. Treasury that was equal to more than 2.5% of total federal income tax receipts. By 2004, the contribution of these programs to federal coffers will grow to more than 3% of projected federal income tax receipts.

The bad news that is after 2004, in just two short years, this net surplus will begin an accelerating decline. By 2010, just eight years from now, the 2004 contribution of 3% of total income tax receipts to the U.S. Treasury will become a deficit. Rather than providing funds that add to federal income tax revenues, these programs will require a transfer from these same federal income tax receipts and begin to impinge on other federal programs. Moreover, the magnitude of the required transfer from federal income tax receipts will grow rapidly so that by 2015 more than 6.5% of all federal income tax receipts will have to be transferred to meet program expenditures.

The problem doesn't end in 2015 because the required transfers will continue to grow rapidly. By 2020, in order to maintain current program benefits, these three programs will require a transfer from the Treasury of almost 16% of all federal income tax receipts. The transfer will grow to more than 35% of federal income tax revenues by 2030 and by 2040, a year before the current estimate of Social Security Trust Fund exhaustion and almost ten years before newly entered workers will retire, these programs will require almost 44% of total federal income tax receipts.

In spite of Social Security's problems getting most of the press, Medicare is already in deficit and its' financing future is much more ominous. Last year, Medicare Part A and Medicare Part B together, required a transfer from the U.S. Treasury that was equal to more than 5% of total federal income tax receipts. By 2010, just eight years from now, and at the front end of the baby boomer retirement wave, Medicare will require the transfer of more than 6% of all federal income tax receipts to pay benefits forecast by the Trustees under current law. This transfer will grow rapidly so that by 2015, the year before the Trustees forecast that HI expenditures will exceed HI revenues, 8.5% of all federal income tax receipts will have to be transferred to Medicare.

Because of the expected growth in health care cost, the required transfers will continue to grow rapidly. By 2020, in order to maintain current program benefits, Medicare will require a transfer from the Treasury of 11.9% of all federal income tax receipts. The transfer will grow to more than 21% of federal income tax revenues by 2030, the year before the Trustee's forecast the exhaustion of the Medicare HI Trust Fund. By 2040, a year before the current Trustees estimate of Social Security Trust Fund exhaustion and almost ten years before newly entered workers reach retirement age, Medicare will require a transfer of more than 28% of total federal income tax receipts in order to maintain current law benefits.

Over the next 20 years, forecast Medicare benefits as a percent of earnings will grow 50% implying a contemporaneous tax rate of 6.33% in 2022. By 2030, all the Baby Boomers will have retired, and the tax rate necessary to pay their benefits in that year is 8.12%. If the status quo intergenerational financing of Medicare is maintained, tax rates will continue to rise reaching 10.0% of payroll in 2040 and 18.13% of payroll in 2080. All during this time premiums for Part B will also be rising, from their 2002 level of \$648 per year, or about 6.3% of an average retiree's Social Security benefit to premiums will rise to \$3,000 in 2075, about 13% of average scheduled Social Security benefits.

As these figures make clear, Medicare, as it is currently structured, is going to become more and more of a general revenue transfer financed program. In 2001, 25% of Medicare expenditures were financed from general revenues. This proportion rapidly rises as the baby boomers retire. In 2010 more than 27% of Medicare expenditures will be general revenue financed and by 2015 more than one-third of all Medicare expenditures will be financed via general revenue transfers. The size of the required general revenue transfer continues to rise rapidly reaching almost 40% of expenditures by 2020, and 47% by 2025. By 2030, the year before we as Trustees forecast that the Medicare HI Trust Fund will be exhausted, more than 52% of all Medicare expenditures will be financed by transfers from general revenues and by 2040 almost 60% of all Medicare expenditures will be financed via transfers from general revenues.

Clearly, elderly entitlement programs are out of control. If nothing is done, by 2060, the combination of Social Security and Medicare will exhaust more than 72% of a federal budget that remains at the current budget's share of the nation's gross domestic product. By way of comparison, these two programs today account for only 37% of federal expenditures.

The promises implied by the Social Security and Medicare programs are essentially debts that must be paid by future taxpayers. Using the estimated costs of Social Security and Medicare from the 2002 Trustees Reports, we can calculate the size of Social Security and Medicare debt. This exercise is useful because it points out the staggering size of the promises we have made compared to what we usually refer to as the public debt. In 2001, the value of U.S Treasury debt held by the public was \$3.32 Trillion. In contrast, the present value of Social Security promises was \$12.92 Trillion and the present value of Medicare promises was a staggering \$17.4 Trillion. Between now and the time it takes for the baby boomers to move through retirement, we will have to pay off all of this Medicare and Social Security debt. In doing so we must bear in mind that the retired baby boomers are going to eat real food, live in real houses, drive real cars and use real hospitals, doctors and nurses. The young will have to produce all this output, essentially paying off the huge debt by consuming less while the retired baby boomers consume more of the nation's output.

These numbers, while staggering, are not meant to frighten, although they are frightening. They are based on the best estimates that we as Trustees of the Social Security and Medicare trust funds are able to put together. If not meant to frighten, they surely represent a sobering reality. The question to ask as you consider changing Medicare is: How any changes will impact on Medicare's already dismal financial future?

### **Changing Medicare for the 21<sup>st</sup> Century**

In spite of the substantial funding challenges facing Medicare, as it is currently structured, Medicare offers second rate coverage of health related episodes. The role of pharmaceuticals in health outcomes is much more important than it was at the inception of Medicare. In spite of the increased efficacy of pharmaceuticals in health outcomes, current Medicare makes non-pharmaceutical components of care cheaper than pharmaceuticals. As a result, Medicare recipients have incentives to substitute physician and other covered components of health care for what would be less expensive and more efficient pharmaceutical treatment. Essentially, the current structure of Medicare discriminates against pharmaceuticals and results in more costly and less effective health care.

This said, given the bleak financial future of Medicare, what can be done to bring pharmaceutical coverage into the program without further endangering the financial future of the program?

First, we must take steps to make both providers and beneficiaries care about the cost of care. One approach toward this end is to combine both Parts A & B of current Medicare into one program. This new program should include pharmaceutical coverage just as standard health coverage for the working population does.

Second, we must include catastrophic coverage. This latter issue would eliminate the need for beneficiaries to purchase Medi-Gap coverage. In fact, Medi-Gap would disappear from the market because of adverse selection. Without Medi-Gap's first dollar

coverage, users of the health care system would begin to care about cost. Importantly, if users care about cost, providers would quickly begin to care about costs. These incentives would result from a single, higher deductible on the unified package. Suddenly, cost reducing technological developments would begin to have the same benefits to providers as they do in other industries. We might begin to see billboards for health procedures similar to those we see for Lasik surgery, where price plays the dominant role. I dream of the day when I will see a billboard for a doctor or hospital where the most dominant thing is the price of the service being offered.

Third, we must increase the freedom of health care markets to work. Our current approach of fixing the price of medical services through MedPac essentially circumvents normal market forces. If we give beneficiaries a greater role in the choice of health care plan in a way similar to the Federal Employee Health Benefit Plan approach, we can increase provider competition. To do so, however, requires that we make a greater effort to make all Medicare beneficiaries equally desirable to providers.

### **The Choice between Tax Financing and Saving**

As we have seen, Medicare will require substantial transfers from the rest of the federal budget. Without substantial restructuring, simply adding prescription drug coverage will increase Medicare's costs. Medicare's funding gap, even as projected without a prescription drug benefit, gives rise to considering other funding alternatives. One such alternative to have people save more for their retirement. Additional savings now can be used to lessen the tax burden required under the present financing arrangement.

Comprehensive Social Security reform proposals often include increased savings as a key component, but in the context of Medicare reform, increased saving is seldom mentioned. Because Medicare is an in-kind benefit conditional on use of the health care system, benefit growth is affected by both changing preferences and changing technology. As a result, identifying the right amount of additional saving is difficult. But regardless of the difficulty in forecasting, funding future Medicare will require imaginative ways to meet its costs.

Current Medicare reform proposals address Medicare's growing financial burden by advocating increased competition in the delivery of care. In the longer term, Congress will need to think about funding alternatives including incentives to save for retirement health care.

### **Conclusion**

In the debate concerning changes in Medicare that will allow the addition of a prescription drug benefit, it is important to consider how these changes will impact on current Medicare's precarious financial condition. The deficits projected by the Trustees in the 2002 Annual Report of the Boards of Trustees are especially significant. If no changes are made in Medicare, it will rapidly become the tail that wags the federal budget dog. By 2030, Medicare alone will require more than 21% of all federal income tax

revenues. When coupled with the transfers to pay currently scheduled Social Security benefits, total transfers of general revenues to keep these programs intact will require more than 35% of federal income tax revenues in 2030. If other federal programs are to remain at anything like their current size, dramatic action will be required.

Thus, as we change Medicare to update its coverage, we should introduce incentives for market forces to work toward controlling the future cost of care. The impetus to incorporate prescription drugs into Medicare presents a unique opportunity to bring Medicare into the 21<sup>st</sup> century. Redo Medicare so that the need for beneficiaries to purchase Medi-Gap will be eliminated. The elimination of Medi-Gap will increase incentives for users and providers alike to care about cost. We should rethink both the structure and financing of Medicare. A new Medicare that combines Parts A & B and includes both prescription drug and catastrophic coverage into a single entity with a combination of premium and tax financing is a start. We must then make the market for this new Medicare one where the normal forces of competition work to control the cost of medical care. This can be accomplished if both users and providers care about cost.